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HOSPITAL AND TRAINING SCHOOL ADMINISTRATION

IN CHARGE OF

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RECORD OF PATIENTS AND ANNUAL REPORT

Considerably more than a decade ago, a nurse superintendent of a hospital expressed a doubt, in a public meeting, of the accuracy of the average annual report of the modern American hospital. For this she was censured and rebuked, but aside from the taste displayed in bringing the matter before a promiscuous gathering there was little in the incident to be called questionable.

The annual report of the average small hospital is often too incorrect to be valuable. This statement is made regarding the small hospital for two reasons: First, the figures being fewer, the mistakes are more noticeable and, second, the great working force of clerks, etc., in a large hospital is likely to be more accurate by reason of the individual attention it is possible to give the compilation of statistics.

Too often the figures which are intended to be statistics have to be juggled in one place to make them balance in another. This is not done because of the desire of any one to misrepresent facts or figures, but because the methods of the registry of patients are too incomplete to permit the busy superintendent with her multiple duties, to rely upon them when, at the end of her hospital year, she attempts to compile statistics for the annual report.

A small hospital once had such a report completed and presented to the printing committee to do the rest. The chairman of the printing committee, who was an accurate business man, saw so many flaws in the statistics alone that he refused to have it printed, declaring it was better for the hospital to forego the annual report than to put forth such a mass of inaccuracies. Needless to say, the stand taken by the chairman of the committee caused considerable disturbance among the professional men who were responsible for the statistics, some of whom felt it to be too small a matter to engage their serious attention, but who were unwilling that their large showing of good work done during the year should pass unannounced and unrecognized. Because

the chairman was capable, patient, willing to work himself and un-mindful of any criticism, and because the professional men were large-minded and really solicitous for the good name of the hospital, the little difference proved one of the greatest blessings to come to the work of that hospital along that line. The chairman said, "Let us straighten this out in a scientific way and we shall have something worth while." Accordingly, a copy of the International Classification of Causes of Sickness and Death was obtained from the Department of Commerce and Labor at Washington, and a new classification was made upon that basis, resulting in an annual report which was correct and of which everybody was proud. The knowledge thus gained by that chairman led to an investigation of the methods of record and register-keeping in that institution, followed by deep study for exactness and simplification that terminated in a system which enables the clerk to keep such a record of patients, their admissions, discharges, diagnoses, etc., from day to day and month to month, that on the last day of the hospital year his statistics are practically complete and ready for the printer.

A system which one of the smaller hospitals has found workable, simple, and correct is as follows: When a patient is admitted to the hospital ward, either he or his accompanying friend or relative gives the nurse in charge the information necessary to fill out the following card:

[FACE]	[REVERSE]
Number —	
— Hospital	
PATIENT'S ADDRESS AND HISTORY CARD	
Patient.....	Age.....
Address.....	Birthplace.....
Ward.....	Occupation.....
Sent in by.....	Religion.....
Date admitted.....	Time admitted.....
Date discharged.....	How sent.....
Relative or Friend.....	Temperature.....
Address.....	Pulse.....
Relation.....	Respiration.....
Telephone.....	Memoranda.....
[Over]	

In the case of an obstetrical patient, the card is of a distinguishing color, the face of which is identical with the above but the reverse side calls for more specific information, made necessary by the fact that births must be recorded at the city or town hall; it is as follows:

[REVERSE]

History

(Obstetrics)

Patient.....
 Maiden name.....
 Birthplace.....
 Age.....
 Occupation.....
 Religion.....
 Time admitted.....
 How sent.....
 Temperature.....
 Pulse.....
 Respiration.....
Husband.....
 Name.....
 Age.....
 Residence.....
 Birthplace.....
 Occupation.....
Baby
 Time of birth.....
 Sex.....

[Over]

These cards, which are 6 inches by 4 inches, are, at the end of the day, deposited in a box like a large postal box, from which they are all collected in the morning and put with others of their kind collected on previous mornings, in a loose leaf book, to be kept at the telephone desk for handy reference so long as the patients represented remain in the hospital. When the patient leaves the hospital, his card is removed from the book and is filed away after all necessary entries regarding his discharge are made upon it.

In order to make the collection of cards in the loose leaf book balance with the number of patients actually in the hospital, it is necessary to render an account of the patients in each ward, to the office keeping the records. Accordingly, when the nurse deposits the history cards of new patients in the postal box she deposits also a report of the ward statistics. This may be simple or elaborate as desired but it should read something like this·

[Page II. Reverse of Page III]

..... HOSPITAL
RECORD OF PATIENTS

YEAR ENDING AUGUST 31, 19													Diagnosis
Date of Discharge													
Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May	June	July	Aug.		
												Brought Fwd.	
												Total	

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..... HOSPITAL
RECORD OF PATIENTS

No. A 19

NAME	AGE	RESIDENCE	NATIVITY	TERMS	REMARKS

The three pages thus made (I, II, III) constitute the patient's record book; each patient has the one line containing his number on the widest page, running clear across that and page II, while his name is on the corresponding line on the top page, or page III. These pages measure $8\frac{1}{2}$ by 11 inches and are ruled to contain the names and records of fifty patients. They are loose leaves and are kept in a book made to fit them.

It will be noted that in order to complete the record, it is necessary to have the diagnosis which is called for on page II. It is not recorded until the last entries are made when the patient is discharged, because then it is possible to secure one revised perhaps from many, and at the same time the condition of the patient. Accordingly, there is kept in each ward a package of so-called diagnosis slips of which the following is a sample, 3 inches by 5 inches:

[FACE OF SLIP]	[REVERSE OF SLIP]
<div>————— Hospital</div> <div>19</div>	
Name.....	Operations:
Diagnosis.....	
To be discharged.....	
Condition at discharge (X).....	
Well.....	
Improved.....	
Not improved.....	Complications:
Dead.....	
Transferred.....	
Not treated.....	
Dr.....	
Time discharged..... <div>{ A.M.</div> <div>{ P.M.</div>	
See other side for operations and complications	

One of these slips or cards must be presented to the doctor in the ward when he announces that his patient is ready for discharge. He immediately fills it out and it then constitutes an order for discharge as well as furnishes the information necessary to complete the record. No patient is discharged without this order.

The diagnosis slips are filed at the end of the month according to the diagnosis they contain and never numerically nor alphabetically. The file is formed under headings furnished by the International Classification of Causes of Sickness and Death and is therefore uniform from year to year.

It is from this file that statistics for the annual report are compiled as found on pages IV and V, whose numbers must agree with the numbers found on page VI, which is really the summary page of the record book and, being kept monthly, is intended to at once indicate and locate an error or omission.

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..... HOSPITAL

Year ending August 31, 19

MEDICAL CASES DIAGNOSIS	IN HOSP. SEPT. 1, 19	ADMITTED			DISCHARGED				REM. AUG. 31, 19	TOTAL TREAT- ED
		Sept. 1, 19 to Aug. 31, 19			Sept. 1, 19 to Aug. 31, 19					
		Male	Fem.	Total	Well	Imp.	Not Imp.	Dead		
Brought Fwd.										
Total Carried Forward.										

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Page 7.

..... HOSPITAL											
Year ending August 31, 19											
SURGICAL CASES DIAGNOSIS	IN HOSP. SEPT. 1 19	ADMITTED			DISCHARGED				REM. AUG. 31, 19	TOTAL TREAT- ED	
		Sept. 1, 19 to Aug. 31, 19			Sept. 1, 19 to Aug. 31, 19						
		Male	Fem.	Total	Well	Imp.	Not Imp.	Dead			
Brought Fwd.											

Pages IV and V are the copy furnished the printer from the file of diagnosis slips previously mentioned and the statistical portion of the annual report is correct and complete.

HOSPITAL

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Year Ending August 31, 19

[illegible]